Editorial

The Harry L. Arnold Jr. MD Hawaii Medical Journal Case of the Month

Norman Goldstein MD
Editor

Harry L. Arnold Jr. MD

A new feature for the Hawaii Medical Journal will be introduced with the January 1998 issue. Our new monthly feature, "The Harry L. Arnold, Jr. MD / HMJ Case of the Month" will publish case reports from Hawaii.

Reports accepted for publication should represent uniquely Hawaiian, or Pacific Basin, subject matter. We encourage submissions from Hawaii and other Pacific Basin locations. Our medical practices are rich in content, and this new forum will allow sharing of topical issues in a brief report. We will limit the content to no more than 2 published pages, with no more than 2 total figures, tables, or images, and 10 or fewer references. The Instruction to Authors are published in the June 1997 HMJ issue on page 157.

The purpose of the column is to introduce a forum for presentation of medical problems which are of interest and importance in our region. There are many medical conditions in our region (e.g. Kava dermopathy, leptospirosis, Hansen's disease, tropical pyomyositis) which are culturally or epidemiologically unique. A case report format allows academic discussion of some relatively rare conditions, and serves to refresh the knowledge of those geographically singular diseases we may have come to regard as commonplace. The HMJ will thus become a repository for reports of those disease processes requiring unique knowledge for treatment and diagnosis in our Medical Ohana.

This new feature will honor the Editor of the Hawaii Medical Journal for 41 years, Harry L. Arnold, Jr. MD.[1] We are pleased that Benjamin W. Berg, MD will serve as editor for this new section.

References

1. Goldstein , N. Editor: Harry L. Arnold, Jr. MD Festschrift; HMJ Nov 1982, 41, 387-454.

Presidents Message

Leonard Howard MD

In this first message to you as your president, I would like to share with you my thoughts about the role of the HMA in the current medical practice environment. We constantly hear comments that the reason we don't have physicians beating down our doors to join is that we lack relevance. Is this really the case, or are other factors impacting on us? What does the charge mean? The term itself is simple: **Relevant** - *bearing upon or relating to the matter in hand; pertinent; to the point.* Let us look at some of the current and some continuing activities of the HMA and see if we lack relevance. What is going on now that is of concern to the HMA?

PGMA bankruptcy - When it was announced that PGMA was folding and that many thousands of patients would be without care, and that many physicians would not receive payment for care already delivered to subscribers, the HMA got involved. We attended the court hearings, listened to the legal dealings, and realized that the physicians were going to take their place far down the line of individual creditors if the stated goal of "Keeping the hospitals happy" was carried out. When this was reported to HMA Council, Dr Ali Bairos reported his solution of filing a small group lawsuit. Council voted to join with Dr. Bairos and, in addition, survey all HMA physicians as to their outstanding claims. When all reports were in, the HMA physicians, as a group, represented by far the largest creditor. Dr Spangler and I set up a meeting with the State Insurance Commissioner, Rey Graulty, and the lawyers handling the reorganization process. The concerns of the HMA were expressed, and we received assurances that the HMA would be treated in the same manner as the hospitals, pharmacies, and other health care providers. In September we received a progress report from Mr Graulty's office which affirmed this assurance. A summary of this report will be published in the Hawaii Medical Newsletter. Relevant? You bet!

Tort Reform - In mid-September we received a notice from the Committee on Judiciary of the House that there would be a Public Hearing on Tort Reform held on Oahu Thursday, November 13, 1997. Because we represent the physicians of Hawaii, we were sent this notice, requesting us to testify. Our testimony is already drafted, and will be presented to Chairman Tom's committee at the hearing. We were already aware of the Administrative interest in Tort Reform because of an invitation to join a coalition of interested parties to lobby for tort reform in this coming session. Your HMA was represented at the first two meetings of the coalition, where we were very forthright in our insistence that relief from joint liability would not be extended to the tobacco industry. When the tobacco lobbyist showed up at the second meeting and offered RJR money to put on a dinner on Maui, we withdrew from the coalition. HMA Council approved this action. In this situation, the HMA will provide strong testimony for tort reform as we did in the past. Our last involvement with tort reform resulted in the formation of the Patient Conciliation Panels, one of the most successful methods of reducing the number of medical malpractice suits in Hawaii.

Relevant? You Bet!

The Times are a-changin - Where is the HMA on the evolution of managed care in Hawaii? We stand right alongside the AMA insisting on **physician control** of managed care organizations. AMNews top story Jan 20, 1997 reported that for all physicians, the percentage holding managed care contracts increased from 55.7% in 1986 to 69.6% in 1992. I don't think the direction has changed since then. For the young physicians, 0-5 years in practice, the figures are 56.5% and 72%, respectively. Maybe the reason we do not attract young physicians as members is because we are being perceived as a solo-practice-only organization, and the younger physicians are not interested. If we are to represent and be advocates for **all** the physicians of Hawaii, it is necessary that we not take a strong stance on any position that positively affects one group of physicians but negatively affects another. The HMA must support the **freedom of choice** for patients to see the physician they want, and the right of the physician to practice in the situation in which he/she chooses. There are many issues that affect **all** physicians in Hawaii. It is in these issues we find our relevance.

Medical School Hotline

Role of the Clinical Faculty in Pediatric Medical Education

Richard Y. Mitsunaga, M.D., F.A.A.P.
Clinical Professor, Department of Pediatrics
John A. Burns School of Medicine
University of Hawaii

In 1984, fewer than 5% of all physician-patient contacts resulted in hospitalization. Nevertheless, clerkships for trainees at all levels were predominantly hospital-based inpatient experiences.[1] Over time, academic departments and training programs evolved to be subspecialty based and located in tertiary care centers which had scant contact with the physicians who referred the cases.

Of course, many specialties require a primarily in-patient experience of its trainees; this is particularly true of the surgical fields and most medical sub-specialties. Practice in the primary care areas, on the other hand, is mainly an out-patient experience and becoming increasingly so because of medical advances and other forces including managed care.

Like other primary care specialists, pediatricians have noted that a larger portion of their patients who previously required hospitalization are now routinely managed on an out-patient basis. The combination of the increasingly ambulatory nature of pediatrics and the validity of classic, in-patient based training of pediatricians was generating more and more questions.[2]

In Hawaii the Department of Pediatrics at the John A. Burns School of Medicine (JABSOM) is the direct descendent of a community hospital residency program at Kauikeolani Children's Hospital. The program was integrated into JABSOM 24 years ago with Dr. Sherrel Hammar as Chairman and Professor. He made two important decisions which have guided the program since its inception as a university residency: (1) Every in-patient would be a teaching patient and (2) Clinical faculty would be an integral part of the program.

The clinical faculty who augmented the small number of faculty emphasized to the house-staff that patient care is a continuum which starts with an out-patient diagnosis, admission and hospital treatment, and post-hospital follow-up. The manner in which clinical faculty are utilized in the Department of Pediatrics has evolved over the years by observing four principles:

One, all pediatric admissions to Kapiolani Medical Center for Women and Children are teaching patients. Admitting pediatricians, whether clinical or regular faculty are expected to interact with residents of different levels according to a protocol designed to maximize the teaching value of the patient for the resident. (This protocol was redefined at a joint resident-faculty retreat in 1997). This interaction determines the day-to-day management of the patient.

Two, teaching on the general pediatric ward is accomplished by a team of two regular and two clinical faculty members who are assigned one month rotations. Accordingly, twenty-four clinical faculty members spend part of each week-day morning for a month tending to teaching duties.

The residents benefit from the perspective that the clinical faculty can give on inpatients regarding pre and post hospital management, family dynamics and use of community resources. The clinical faculty benefits from the close exposure to residents, regular faculty and the stimulus of working on a hospital service. The Department of Pediatrics experiences no difficulty in obtaining volunteers for this duty.

Three, clinical faculty members provide community-based ambulatory experience for residents as well as medical students. In contrast to the hospital based ambulatory experience which provides care for children who need primarily ongoing sub-specialty care, the community-based ambulatory experience focuses on continuity, wellness, family dynamics and common illnesses which are managed in the office.

The community-based ambulatory experience with clinical faculty members offers residents more than patient management. It is their introduction to office practice. Residents have their choice of practice setting from solo or small group practice to large staff-model multi-specialty groups. Residents are exposed for the first time to considerations regarding an office's physical design; business aspects such as employee matters, accounting, billing and collections, and medical records systems; appointment systems and telephone techniques; patient flow; purchasing; and office meetings. Residents can also learn about issues which confront physicians such as division of responsibilities, decision making, continuing medical education and dividing income; nursing job descriptions; special office areas (hearing and vision screening, minor surgery); office laboratory procedures and relations with local specialists such as pharmacists, school counselors and other community resources.[3] The rotation can be tailored to address each resident's interests and needs.

Four, clinical faculty who are subspecialists provide rotations in their offices or in the clinic for experience within their sub-specialties.

The validity of the educational approach utilizing clinical faculty and community experience by the Department of Pediatrics has